Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: July 17, 2023
Original Report Issue Date: May 9, 2023
Inspection Number: 2023-1193-0004 (A1)
Inspection Type: Complaint Follow up Critical Incident System
Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partner
Long Term Care Home and City: Orchard Villa,Pickering

Amended By	**Inspector who Amended Digital Signature**
Patricia Mata (571)	Patricia Mata Digitally signed by Patricia Mata Date: 2023.07.16 14:09:45 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to reflect the rescinding of Compliance Order (CO) #001 under O. Reg. 246/22, s. 54 (2) and Administrative Monetary Penalty (AMP) following a Director Review. Inspection #2023-1193-0004 was completed on April 3-6, 11-14, 2023.

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Lead Inspector Fatemeh Heydarimoghari (742649)	**Additional Inspector(s)** Deborah Nazareth (741745) Miko Hawken (724)
Amended By Patricia Mata (571)	**Inspector who Amended Digital Signature** Patricia Mata Digitally signed by Patricia Mata Date: 2023.07.16 14:10:20 -04'00'

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 3, 4, 5, 6, 11, 12, 13, 14, 2023
The following intake(s) were inspected:
. An intake related to Follow-up to Compliance Order (CO) #001 from Inspection #2022-1193-0002 related to falls prevention and management.

- Five Intakes related to staff to resident abuse.
- A CIR Intake related to alleged neglect.
- Two Intakes related to improper care of resident by staff.
- A CIR Intake related to fall prevention and management.
- A CIR Intake related to missing resident.
- A complaint intake related to training and supplies.

The following intake(s) were completed in the Critical Incident System Inspection:
Two CIR Intake related to a missing resident. A CIR Intake related to supplies and resident care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1193-0002 related to O. Reg. 246/22, s. 54 (2) inspected by Fatemeh Heydarimoghari (742649)

The following **Inspection Protocols** were used during this inspection:

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

1. The licensee failed to ensure the alleged physical abuse of a resident was reported immediately to the Director.

Rationale and Summary

An incident of alleged physical abuse of a resident by Personal Support Worker (PSW) #110, was reported to the Director.

The Critical Incident Report (CIR) indicated that Registered Practical Nurse (RPN) #109 was informed by the resident that they had to defend themselves while PSW #110 provided care.

Registered Nurse (RN) #106 and the Director of Care (DOC) confirmed RPN #109 did not investigate the resident's statement or inform their supervisor of the incident immediately.

According to the LTCH's policy "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", anyone who witnesses or suspects abuse or neglect of a resident by another resident, staff or other person must report the incident. At a minimum, any individual who witnesses or suspects abuse or neglect of a resident must notify management immediately.

RN #106 and the DOC confirmed that RPN #109 should have reported the incident immediately to their supervisor and an investigation should have started immediately.

By not reporting the incident of alleged abuse and starting an investigation immediately there was a risk of further incidents towards the resident.

Sources:
Interviews with RN #106 and DOC. The LTCH's investigation notes, discipline letter for PSW #110. Resident's plan of care, progress notes and clinical record. CIR. The home's policy "Zero Tolerance Response & Reporting.

2. The licensee failed to ensure the alleged physical abuse of a resident was reported immediately to the Director.

Rationale and Summary

An incident of alleged physical abuse of a resident by PSW #124, was reported to the Director. An incident was reported to RN #128 by the resident's Power of Attorney alleging PSW #124 agitated and upset resident the by removing and throwing their communication device at them. A second progress note documented by RPN #129 indicated the same. The resident's POA also requested PSW #124 no longer provide care to the resident as they were concerned the PSW would not provide care properly. PSW #124 continued to provide care to the resident for six more days after the incident.

According to the LTCH's policy "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", anyone who witnesses or suspects abuse or neglect of a resident by another resident, staff or other person must report the incident. At a minimum, any individual who witnesses or suspects abuse or neglect of a resident must notify management immediately.

The DOC and the Director of Clinical Care (DOCC) #118, acknowledged the incident was not reported to management or the Director immediately.

As a result of not reporting the allegation of abuse immediately the home's investigation was delayed and PSW #124 continued to provide care to the resident, placing the resident at risk for further incidents.

Sources:
Interviews with PSW #124, DOCC #118, DOC #101 and others. Resident progress notes and clinical record. LTCH's investigation notes and the home's policy "Zero Tolerance Response & Reporting. CIR. [741745]

3. The licensee failed to ensure that witnessed physical abuse to a resident by a PSW was reported immediately to the Director.

Rationale and Summary

The home submitted a CIR indicating that a POA of a resident reported to the Clinical DOC, multiple examples of alleged abuse by PSW #111. The Clinical DOC did not immediately report the allegations to the Director.

The DOC confirmed the incident should have been reported immediately by the Clinical DOC to the Director on day of the incident and not the day after the alleged abuse was reported.

There was a risk to the resident when this allegation of staff to resident physical abuse was not reported immediately to the Director as it would delay the home's investigation process and put residents at an increased risk of further incidents.

Sources:
CIR, interview with DOC. [724]

WRITTEN NOTIFICATION: Protection from certain restraining

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 34 (1) 1.

The licensee failed to ensure that a resident was not restrained for the convenience of the staff.

Rationale and Summary

A CIR was reported to the Director, alleging that a resident was improperly restrained.

PSW #120 barricaded the resident in bed so the resident could not get out of bed and went on break. The staff member acknowledged that they should have not barricaded the resident in bed as it was considered improper restraining.

By failing to ensure the resident was not restrained for the staff's convenience, the licensee put the resident at risk for injury.

Sources:
A CIR, resident's plan of care, interview with PSW #120. [571]

WRITTEN NOTIFICATION: Training

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)

The licensee failed to ensure that PSW #120 received annual retraining on the long-term care home's policy to minimize the restraining of residents, as specified in s. 82 (2) 6. of FLTCHA, 2021.

Section 260. (1) of O. Reg. 246/22 directs the retraining intervals for the purposes of subsection 82 (4) of the Act is to be annually.

Rationale and Summary

A CIR was submitted to the Director, alleging that a resident was improperly restrained by PSW #120. PSW #120 acknowledged they had improperly restrained the resident. They could not recall the last time they had received training on the long-term care home's policy to minimize the restraining of residents.

A review of PSW's #120's education records indicated that they did not receive the required retraining for that year on the long-term care home's policy to minimize the restraining of residents.

The Director of Care (DOC) acknowledged that PSW #120 needed to be retrained in 2022.

By failing to ensure PSW #120 had completed the required retraining on the long-term care home's policy to minimize the restraining of residents, the licensee put the resident at risk of potential harm.

Sources:

CIR, education records for PSW #120, interview with PSW #120 and the DOC. [571]

WRITTEN NOTIFICATION: Doors in a home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee failed to ensure that the door to the room containing the laundry chute and the door to a supply closet on the secured unit was locked.

Rationale and Summary

During the initial tour of the long-term care home, the door to the room containing the laundry chute on a RHA was observed to be unlocked. In addition, the door to a supply closet on a separate RHA was found to be unlocked, and the lock was broken.

The lock on the door for the room containing the laundry chute was not engaged and the batteries were not functioning. Residents were observed wandering the unit.

The supply closet was cluttered with the following: a Hoyer and a sit-to-stand lift; shelves with incontinent products and boxes of miscellaneous items such as paper cups; two carts; PPE bins and milk carts stacked to the ceiling; boxes on the floor; and large and small garbage bins.

Resident Care Coordinator (RCC) #116 and RPN #112 stated that they had reported that it was broken but it had not been repaired.

By failing to ensure the door to the room containing the laundry chute and the door to the supply closet were locked, the licensee put the residents at risk for injury.

Sources:
Observations and interviews with RCC #116 and RPN #112. [571]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident with their care.

Rationale and Summary

A CIR was submitted to the MLTC related to resident care issues. The resident's plan of care indicates that two staff are required to provide care to the resident. PSW #110 provided care but did not get another staff member to assist.

The DOC confirmed that PSW #110 did not follow the resident's plan of care as they did not have a second staff member with them as required when transferring and positioning the resident. There was a risk for injury to the resident when PSW #110 did not follow resident's plan of care and use safe transferring and positioning techniques.

Sources:
Interviews with RN #106 and DOC. The LTCH's investigation notes, discipline letter for PSW #110. Resident's plan of care, progress notes and clinical record. [741745]

WRITTEN NOTIFICATION: Bedtime and rest routines

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 45

The licensee has failed to ensure that a resident's desired bedtime and rest routines were supported and individualized to promote comfort, rest, and sleep.

Rationale and Summary

A CIR was submitted to the MLTC related to resident care issues. The resident's plan of care indicated that the resident received care at a specified time. PSW #110 provided care to the resident despite the resident expressing that it was not time for them to receive care. This upset the resident.

The DOC acknowledged that PSW #110 did not support the resident's desired care routines when they forcibly provided care to the resident and transferred them to bed early.

PSW #110's failure to follow the resident's desired care routines resulted in the resident feeling disrespected and posed a risk to their comfort, dignity, and sleep.

Sources:
Interviews with RN #106 and DOC. The LTCH's investigation notes and discipline letter for PSW #110. Resident's plan of care, progress notes and clinical record. [741745]

WRITTEN NOTIFICATION: Responsive behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee failed to ensure that where strategies were developed to respond to resident's responsive behaviours, they were implemented.

Rationale and Summary

A CIR was submitted to the Director, alleging that a resident was improperly restrained and left alone by PSW #120.

A review of resident's plan care in place at the time of the incident was specific to the resident. PSW #120 did not follow the plan of care when they improperly restrained the resident and left them alone.

Education records specific to the resident's plan of care indicated that education was provided to PSW #120. PSW #120 acknowledged that they did not follow the resident's plan of care when they barricaded the resident in bed and left them alone.

By failing to ensure RPN #120 followed the resident's plan of care, the licensee put the resident at risk of harm and injury

Sources:
CIR, in-service records, resident's plan of care and interviews with PSW #120 and the DOC. [571]

WRITTEN NOTIFICATION: Housekeeping

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (d)

The licensee has failed to ensure that procedures are developed and implemented to address lingering offensive odours.

Rationale and Summary

On three separate occasions, a strong odour was noted in a specific area of the home.

The licensee's policy titled, "Odours," directs the Environmental Service Manager (ESM) or designate to investigate the source of the odour and, if unable to identify the source of the odour and review the area experiencing odour issues at various times of the day to establish if the odour is ongoing.

Housekeeper #134 confirmed that there was a strong odour in the specified area. They were not provided with a product or process for eliminating the lingering odour. PSW #133 confirmed the odour was always present.

The ESM was unaware of the odour.

By failing to address the strong odour in the specified area, the licensee exposed residents to the offensive odour.

Sources:
Observations, interviews with staff, Odour's policy. [742649]

WRITTEN NOTIFICATION: Laundry service

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (b)

The licensee failed to ensure that a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents.

Rationale and Summary

A complaint was submitted to the Director indicating a concern around linen and towels not readily available for staff to provide resident care and a lack of available towels requiring families to bring bath towels for residents.

During the inspection, on two separate days, at different times, a lack of linen was noted. PSWs #104, #105, #120, #121, and #122 confirmed that there was a continued concern at the home with linen supplies. The staff indicated that linen and towels were not available at the beginning of the shift and that care, such as baths and showers, were delayed for residents, which impacted residents' daily activities. They further indicated that they often go looking for linen in other resident home areas or go to the laundry room when the supply is available for use.

A laundry aide indicated that there was a lack of linens and towels. They also stated that they were not able to sufficiently supply the number of towels and linens, that were required for each

RHA, as indicated on the RHA specific lists, twice per day. The laundry aide also confirmed that staff continually came down to the laundry room during the day shift to get linen and towels so that they were able to complete resident care.

The Executive Director (ED) and the ESM stated that they tried to implement an auditing system to control the required amounts of towels and linens going to the RHA units, but that they were having difficulty with successfully implementing it. They also stated that they had received face towels and hand towels, but bath towels were back ordered from the supplier.

Failure to ensure that linens and towels were available posed a risk to the delivery of resident care and impacts the resident's daily activities.

Sources:
Observations, photographs, interviews with PSWs, ED, ESM. [724]

WRITTEN NOTIFICATION: Maintenance services

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (a)

The licensee failed to ensure the interior areas of the building were maintained in good repair.

Rationale and Summary

During a tour of the home, several areas of the flooring in the common areas were noted to be chipped and missing small sections, especially around drains, drain covers in hallways and shower rooms and around several floor latches for the emergency fire doors. Several areas of scuffed, marked, and peeling paint on walls were noted. In a shower/tub room on the RHA, a section of tiling on the wall was lifting off, and a section of the wall was noted to have been cut out but not repaired.

During an observation of the washroom in a resident room, the vanity was noted to have a missing laminate with exposed chipped particle board. In addition, the right side of the towel rack on the left wall was partially out of the wall.

Housekeeper #130 confirmed that several repairs were needed in the home, including the vanity, which has been in a state of disrepair for a long time.

The Environmental Services Manager (ESM) has been in their full-time position for six months. They are presently implementing maintenance processes such as, completing detailed room

audits to determine repairs that need to be done, making repairs unit by unit until the work is completed, then planning to complete regular maintenance and stripping and waxing of floors every six to 12 months. Going forward, the ESM stated they have started documenting what work has been done. In addition to these processes, managers were to do a walkabout every week and to identify any repairs needed. Front-line staff can enter repairs required on the computer, and the report will go to the ESM.

There was a potential risk to resident safety and the potential for the spread of infectious agents when the home did not implement preventative and remedial maintenance procedures for the walls, baseboards, floors, vanity, and towel rack.

Sources:
Observations, interviews with the ESM and housekeeper #130. [742649]

(A1) Appeal/DREV #: 0004
The following order(s) has been rescinded:

COMPLIANCE ORDER CO #001 Falls prevention and management

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The following Administrative Monetary Penalty (AMP) for CO #001 has been rescinded:

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

(A1)
The following non-compliance(s) has been newly issued: NC #011

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

Summary and Rationale

The licensee failed to ensure that when a resident had fallen, the resident was assessed and that when the condition or circumstances of the resident required, a post-fall assessment was conducted.

A critical incident report was submitted to the Director for a fall. A resident had fallen and was returned to bed by RPN #135 and PSW #136. A post falls assessment was not initiated. PSW #136 noted an injury to the resident several hours later and informed the RPN. A post falls assessment was not initiated at that time. The RPN and PSW did not report the fall to the oncoming shift.

A post falls assessment including head injury routine, were not initiated until six hrs after the initial fall when the staff on the next shift were informed by a co-resident that the resident had a fall on the previous shift. The staff immediately initiated a post falls assessment and Head Injury Routine (HIR). The resident was assessed separately by Nurse Practitioner #139 and Physician #140. Injury was noted and a change was made to the resident's plan of care.

The licensee's policy titled "Falls and Prevention and Management Program" directs the nurse to complete an initial and neurological assessment after a resident has had an unwitnessed fall The DOC confirmed that RPN #135 should have completed a post fall assessment after the resident had a fall.

By failing to ensure a post falls assessment was completed immediately after the resident had an unwitnessed fall, the licensee put the resident at risk for serious harm

Sources:
Critical Incident Report, policies, the resident's progress notes, electronic medication record and interviews with the DOC. [571]